DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
DIVISION OF LONG-TERM CARE

The DMAS MFP Program Enrollment Form, DMAS 222 is required to be completed for participation in the Money follows the Person Program.

Copies should be forwarded to DMAS via secure email or FAX.

MFP@dmas.virginia.gov or (804) 452.5468

If all information is not known at the time of enrollment, it is the responsibility of the Provider (Transition Coordinator or Support Coordinator/Case Manager) to - resubmit the form when it is complete, no more than 30 days after transition.

Questions?

Contact:

Virginia Department of Medical Assistance Services
Long Term Care, Money Follows the Person Program
Phone: (804) 225.3007
mfp@dmas.virginia.gov

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
DIVISION OF LONG-TERM CARE
REQUEST FOR ENROLLMENT
MONEY FOLLOWS THE PERSON PROGRAM (MFP)

Individual's Name:	
Medicaid ID Number:	
Transition Coordinator or Support Coordinator/Case Manager's Name	
Agency Name/Provider ID Number:	

Please check the Medicaid Home and Community Based Service Waiver or Program type the individual is likely to utilize:

❑ EDCD ❑ FIS ❑ CL ❑ TECH ❑ PACE

MFP Eligibility Criteria: (Check each item as it is discussed with the individual.)

❑ Individual has given consent to participate in Money Follows the Person Program.

❑ Individual is a resident of the Commonwealth of Virginia.

❑ Individual has been living for at least 90 consecutive days in a long-term care facility [(LSH) (ICF/IID), (IMD), (PRTF)], or a combination thereof.
(Any days spent in short-term skilled rehabilitation services paid by Medicare do not count towards the 90 days)

From which facility is the individual discharging? One of the following must be checked.

Long-Stay Hospital (LSH)

❑ Nursing Facility (NF)

❑ Intermediate Care Facility for Individuals Living with Intellectual Disabilities (ICF/IID)

❑ Institute for Mental Diseases (IMD)

❑ Psychiatric Residential Treatment Facility (PRTF)

❑ Facility Name:_____

❑ Individual has or will receive Medicaid benefits for inpatient services for at least one day prior to MFP participation.

❑ Individual has received information explaining the Money Follows the Person Program. General information and MFP Brochure may be found at:
http://www.dmas.virginia.gov/Content_pgs/ltc-mfp.aspx

To which QUALIFIED address is the individual transitioning? (Check one box below).

❑ Home owned by the individual

❑ Home owned by the individual's family member

❑ Apartment leased by the individual. The lease is in the individual's name, with lockable entry and exit, and includes living, sleeping, bathing and cooking areas over which the individual or their family has domain and control.

❑ Group Home in which no more than four unrelated individuals reside

❑ Sponsored Residential Placement in which no more than four unrelated individuals reside

❑ Adult Foster Care Home in which no more than four unrelated individuals reside

❑ Assisted Living Facility in which no more than four unrelated individuals reside

Is this person living with family?

❑ Yes ❑ No

Will the individual self-direct (consumer-direct) any aspect of their waiver services?

❑ Yes ❑ No, the individual will be using agency-directed waiver services

Individual's Community Residence Address

(If the address is unknown at the time this form is completed, this information should be submitted to the DMAS MFP staff the day of discharge but no later than 30 days after discharge.)

Participant's Name: _____

Street Address: _____

Apartment Number: _____

City: _____

Zip Code: _____

Phone Number: _____

***Final address and phone number must be provided to the DMAS MFP Staff.**

By submitting this enrollment request, the Transition Coordinator or Support Coordinator/Case Manager:

1. Acknowledges that all criteria listed above have been met.
2. Assures that there is documentation for all criteria listed above.
3. Confirms that the information is available in the individual's record for review.
4. Attests that the individual applying to the MFP program can reside safely in the community based upon the: transition plan, risk assessment/mitigation plan, participant back-up plan, and plan of care, developed during the transition process as required for enrollment into a Medicaid home and community –based program.

_____

SIGNATURE – Transition Coordinator or Support Coordinator/Case Manager

_____

DATE SIGNED

_____

PRINTED NAME- Transition Coordinator or Support Coordinator/Case Manager

_____ _____

PHONE NUMBER **EMAIL ADDRESS**